



Forum Companion Document

For use with ANSI ASC X12N
Health Care Claim: Institutional
Implementation Guide and Addenda

Health Care Claim: Institutional 837

ASC X12N 837 (004010X096A1)

“Developing and Troubleshooting the Transaction”

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Getting an Electronic Version of this Document

An electronic version of this document, and other 837 related documents, can be found at www.wahealthcareforum.org/hipaa/work_products.asp. From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

Participants in the 837I Companion Document Initiative

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and medical groups. For additional information about The Forum see www.wahealthcareforum.org.

Health plans participating in this HIPAA 837I initiative include:

- *First Choice Health Administrators,*
- *Group Health Cooperative and Option Healthcare,*
- *Premera Blue Cross,*
- *Regence BlueShield,*

Professional provider organizations participating in this HIPAA 837I initiative include:

- *The Everett Clinic*
- *Children's Hospital & Medical Center*
- *Group Health Cooperative*
- *Health Services Northwest*
- *Wenatchee Valley Medical Center*

Intended Use of the 837I Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Health Care Claim: Institutional (837I) Transaction.

A complete version on the Implementation Guide can be accessed at

www.wpc-edi.com/hipaa/HIPAA_40.asp.

This Companion Document is designed to help institutional provider organizations, e.g. hospitals in their efforts to:

- *Become familiar with the HIPAA transaction and how that transaction will be processed by participating health plans*
- *Develop software to implement & exchange the HIPAA transaction with participating health plans*
- *Develop specification materials for their vendor(s) who will implement the transaction*
- *Resolve possible issues that might arise in the process of exchanging the transaction with participating health plans.*

*This Companion Document should be a useful guide for provider organizations and other 837I transaction submitters that are exchanging transactions **directly** with participating health plans (listed above).*

This Companion Document is likely to become one part of any trading partner agreement between a provider organization, or electronic submitter, and a health plan. The term, '*trading partner agreement*', is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

All conventions should be stated clearly in the *trading partner agreement* so that implementation and operations expectations are defined unambiguously. Conventions that are established in a *trading partner agreement* take precedence over any conventions that are contained in this document.

This Companion Document may be less useful when a provider organization, or other 837I transaction submitter, is not exchanging transactions directly with participating health plans. Information contained in this document ***may not*** apply to exchanges between:

- Provider Organizations and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Provider Organizations and Clearinghouses: Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this Companion Document. The clearinghouse may reformat the provider's transaction before passing it along to the health plan. This reformatting may add unforeseen complexity to the process of transaction exchange.

Scope of the 837I Transaction

Within Scope of this Document:

The Health Care Claim Institutional transaction is used to convey information from provider organizations and billing organization to health plans about claims for payment for services provided. This includes claims to primary, secondary and/or tertiary payers.

Outside Scope of this Document:

- Claims transactions between provider organizations/billing organization to payers for the purpose of repricing,
- Claim transactions between health plans for the purpose of Coordination of Benefits (COB) are outside of the scope of this Companion Document.
- Information about how a particular claim is adjudicated by a health plan is outside the scope of this Companion Document. That information is contained in a Remittance Advice 835 transaction.

Recommended Business Practices for Exchanging 837I Claims

Claims can be submitted to participating health plans for services that have been delivered to a patient. Health Plans will acknowledge receipt of each batch of claims with a 997 transaction.

At any time after submitting the claim, a provider organization can check on the status of the claim using the HIPAA 276/277 transaction or by accessing the health plans web site. Unless instructed by the health plan, provider organizations should avoid resubmitting claims. Resubmitting claims as a method of checking on claims status will complicate the processing cycle.

When a claim has been processed, health plans will communicate with the provider organization using the HIPAA 835 transaction and/or a paper remittance advice (see the Companion Document for the 835 transaction).

Dictionary of Important 837I Transaction Terms and Definitions

These definitions relate to data elements/descriptions within the 837I transaction and are intended to clarify where information should be placed within the transaction. *Be sure to check with the health plan for their specific billing requirements, e.g. which data elements are required under what conditions.*

Term	Definition
Claim	A bill for services delivered to an individual patient. Within an 837I transaction, a CLM segment identifies each claim.
Batch of Claims	All claims that are contained within an ST-SE Loop of an 837I transaction. (Multiple claims are typically contained within an 837I.)
<ul style="list-style-type: none"> ▪ Institutional Provider Organization ▪ Provider Organization 	Any organization (e.g. hospital) that provides healthcare services to patients.
Attending Physician	Provider with primary responsibility for the patient's medical care and treatment
Operating Physician	Provider who performed the principal procedure
Ordering Provider	Provider who ordered services or supplies. If included on the claim, it should be placed in the 'Other Provider' Data Field in the transaction.
Referring Provider	Provider who referred the patient to the organization or Attending Physician. If included on the claim, it should be placed in the 'Other Provider' Data Field in the transaction.
Pay To Provider	Provider organization to which the health plan will send payment for claims submitted on the 837I.
<ul style="list-style-type: none"> • Billing Organization • Billing Service 	Organization that prepares and submits an 837I transaction on behalf of an Institutional Provider Organization.
<ul style="list-style-type: none"> • Billing Provider • Submitter 	Original sender of the 837I, e.g. Institutional Provider Organization or Billing Organization – whichever sent the electronic 837I transaction
Rejected Transaction	An 837I transaction that was received by a health plan but could not be processed by their system because it was not compliant with HIPAA data formatting or data content requirements.
Rejected Claim	A Claim, contained in an 837I transaction, that was received by the health plan, but was not accepted into their claims processing system
Denied Claim	A claim that was received by a health plan, processed by their system and wasn't paid.
Trading Partner	A Sender (e.g. Institutional Provider Organization, Billing Organization) or Receiver (e.g. Clearinghouse, Health Plan) of an 837I transaction.
Clearinghouse	An intermediary organization between an Institutional Provider Organization/Billing Organization and a Health Plan.

Helpful Hints for Developing the 837I Transaction

This section of the 837I Companion Documents provides hints that may be helpful in developing and submitting an 837I transaction. Following these hints should expedite turnaround time on the claim.

These hints apply to the batch implementation of the 837I transaction. Batch implementation means that the submitting organization sends the 837I transaction to the health plan through some means of telecommunications and does not remain connected while the health plan processes the transaction.

1. Creating an electronic envelop (ISA-IEA) for the claim transaction

The X12N structure allows for either one or multiple transaction types to be transmitted in an ISA-IEA envelope. Participating health plans prefer that each different type of transaction is contained with its own ISA-IEA envelope. For example, if an electronic transmission contains claims and referrals, two ISA-IEA sets are preferred; one for the claims (837I) and one for the Health Care Services Review transaction (278).

2. Structuring the transaction (GS-GE & ST-SE)

- A separate GS-GE set is preferred for each provider organization that originated a batch of claims and for each type of claim, e.g. Institutional (837I), Professional (837P), or Dental (837D).
- Within a GS-GE set, it is preferred that information between an ST and the corresponding SE relate to claims from one Billing Provider (i.e. one submitter/receiver combination). For that Billing Provider, there can be multiple pay-to providers multiple subscribers, multiple patients, and multiple claims.
- The Transaction Set Control Numbers in ST02 and SE02 must be identical. Submitters could begin sending transactions using the number 0001 in this element and increment from that starting point. The number must be unique within a specific functional group (GS-GE) and interchange set (ISA-IEA) but can repeat in other groups and interchanges.

3. Formatting Data in the Transaction

- Any character used in a data element cannot be used as a delimiter, separator, or terminator. Ideally, the following characters should not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , #, :, ~).
- By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 should contain a '2' to indicate a non-person entity.

4. Staying Compliant With HIPAA Transaction Versions and Code Sets

- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, only the legally mandated version of the transaction. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.
- Per HIPAA regulations, institutional provider organizations must submit, and health plans must be able to process, the medical data code sets that are valid at the time that the service was rendered. (The validity of the medical data code set is determined by the service date not the transaction submission date.) This means that health plans must be able to process versions of the code sets that precede the current version.
- Current versions of many of the code sets are available at www.wpc-edi.com/codes/

5. Identifying the Submitting Organization, the Billing Provider & the Pay-To Provider

- The organization that actually submitted the 837I transaction to the health plan is considered the Submitting Organization. That organization should be identified in ISA06, GS02, and in the Submitter Loop 1000A ‘Submitter Name’.

Likely situation: When an institutional provider organization uses a billing service to submit their claims, the billing service is the Submitting Organization.

- The organization that originated the claims is considered to be the Billing Provider. (The Billing Provider and the Submitting Organization will be different if the Billing Provider has a Billing Service prepare and submit their claims to the health plan.) The organization to be paid by the health plan for the services is considered to be the Pay-To-Provider.

For First Choice Health Administrators, Group Health & Options Healthcare, Premera Blue Cross . . .

If the organization that originated the claims is also the organization to be paid by the health plan . . . ***then*** that organization should be indicated in Loop 2000A ‘Billing/Pay-To Provider Hierarchical Level’ and in Loop 2010AA ‘Billing Provider’. Loop 2010AB ‘Pay-To Provider Name’ should not be sent.

If the organization that originated the claims is different than the organization to be paid by the health plan . . . ***then*** the organization that originated the claims should be indicated in Loop 2000A ‘Billing/Pay-To Provider Hierarchical Level’ and in Loop 2010AA ‘Billing Provider Name’. The organization that is to be paid by the health plan should be indicated in Loop 2010AB ‘Pay-To Provider Name’.

For Regence BlueShield . . .

Always put the organization to be paid by the health plan in Loop 2000A ‘Billing/Pay-To Provider Hierarchical Level’ and in Loop 2010AA ‘Billing Provider’. Loop 2010AB ‘Pay-To Provider Name’ should not be sent. If the Billing

Provider and Pay-To Provider are different, the Billing Provider should not be put on the claim.

6. Identifying Attending Physician, Operating Physician and Other Providers

One Attending Physician, one Operating Physician and one Other Provider may be identified at the Claim Level (Loop 2300). Attending Physician information would be put in Loop 2310A, Operating Physician information would be put in Loop 2310B, Other Provider information would be put in Loop 2310C.

Any Attending Physician, Operating Physician or Other Provider identified at the Service Line level — Loops 2420A, 2420B and/or 2420C, respectively, are not used for claim adjudication.

7. Sending Explanation Of Payment information

Ideally, health plans would like to receive the full set of Explanation of Payment (EOP) information as described in Loops 2320 — Other Subscriber Information and 2430 — Line Adjudication Information. However, it is unlikely that institutional provider organizations will have the capability to fully populate these Loops from the Health Care Claim Payment/Advice 835 ANSI ASC X12N transaction (835). As a minimum, professional provider organizations should supply the following information.

EOP Information	837 fields
Other Insured Name & Number	Loop 2330A: <ul style="list-style-type: none"> • NM101= 'IL' • NM102= '1' or '2' • NM103-105 is Other Insurance Name Information • NM108 = 'MI' • NM109 is Identifying Number
Amount Paid by Primary Payer ^{*1}	Loop 2320—COB Payer Paid Amount: <ul style="list-style-type: none"> • AMT01 = 'C4' • AMT02 is Amount Paid
Zero Payment Indicator ^{*2} (only if Primary Payer was billed and paid amount = \$0.00)	See explanatory note #2 below Loop 2300 Segment NTE <ul style="list-style-type: none"> • NTE01='ADD', • NTE02 = 'COB-Z' or information about the \$0.00 payment contained on the paper EOP.
Payer Name	Loop 2330B: <ul style="list-style-type: none"> • NM101= 'PR' • NM102 = '2' • NM103 is Payer Name Information • NM108 = 'PI' • NM109 is payer identification

EOP Information	837 fields
	information (the entered value is unimportant as it won't be used by the health plan)

*1 The 'Amount Paid by Primary Payer' field should only contain the amount paid by the payer, excluding the contract adjustment. (If the coverage from the primary payer is a capitated product, the amount paid will be considered to be equivalent to a fee for service amount. This secondary claim will be processed as all other Coordination of Benefit claims.) Using this field for the amount paid by the patient, such as copay amount or patient responsibility amount, will slow down the adjudication process. When a health plan sees an amount in that field that appears to be a co-pay amount, e.g. \$10 or \$15, the claim will be pended until the other payer can be contacted to confirm that they paid the amount.

*2 The 'Zero Payment Indicator' should be included when the primary payer was billed and remitted \$0.00. (An example of this situation is when the patient's deductible has not been met.)

If the amount paid by the primary payer is \$0.00, the health plan needs additional information from the primary payer. In these situations, ***claims are likely to be turned around faster if they are submitted on paper along with the paper EOP*** from the primary payer.

If you choose to submit the claim electronically, fill in all of the fields outlined in this table;

- If information about the zero payment is not included on the electronic claim, the claim may be denied with an action code indicating that a paper EOP is required.
- Otherwise, the health plan will usually try to obtain the remaining information from the primary payer. If they are unable to do so, the claim will be denied. If this happens, resubmit a paper claim with the paper EOP from the primary payer and be sure to attach the Supporting Documentation Standard Cover Sheet.

8. Testing Your Transaction

Testing your transaction with a validation tool/company is strongly recommended. This process will make it significantly easier to test the transaction with your health plan or other intermediary.

Examples of validation tools/companies include EDIFECS and ClarEDI. These companies are listed as examples. This listing is not intended as an endorsement.

Trouble Shooting Questions and Answers

This section of the 837I Companion Documents provides answers to commonly asked questions that may arise during the process of tracking claims that have been submitted.

1. What acknowledgment should we receive from health plans?

Health plans intend to respond to every 837I transaction received, in most cases with a Functional Response transaction (997). The 997 will be sent immediately upon receipt of the 837 transaction by the health plan.

Per HIPAA regulations, if the information associated with any of the claims in the 837I ST–SE batch is not correctly formatted from a syntactical perspective, all claims within the ST–SE set are rejected. The health plan notifies the submitting organization of the rejection *via* a 997 transaction or other method agreed upon in the *trading partner agreement*. Institutional provider organizations should consider this possible response when determining how many patients and claims they submit in a single 837I ST–SE.

If a 997 shows a rejected batch or batches, the provider organization should fix the error and resend everything that was contained within the ST-SE of the rejected 837I transaction.

If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide and Addenda, AND there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction or will contact the institutional provider organization *via* phone/fax whenever possible. In this case, the batch is not processed.

In all other cases, the health plan responds with an appropriate 997 transaction to acknowledge receipt of the Batch. The 997 transaction indicates whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide and Addenda, the health plan may not be able to process the transaction.

2. What are possible processing issues that might occur at the health plan?

Once an 837I transaction is accepted by the health plan, all claims contained within that transaction will be processed according to their standard adjudication processes. Contact the health plan if you are unclear about their adjudication process.

3. What type of reports will we receive after submitting an 837? Are there situations where submitted claims may not appear on any of reports provided by the health plan?

The following health plans will send a 997 transaction to the sender of each 837I transaction to acknowledge receipt. In addition . . .

Health Plan	Type of Report	Purpose	Comment
First Choice Health Administrators	Unsolicited 277	Identify claims submitted for patients that are not FCH members	
Group Health Cooperative	Letter	Identify claims that were rejected prior to upload into processing system	
Premera Blue Cross	<ul style="list-style-type: none"> • 837 Transaction Error Report • Premera Acceptance Report 	<ul style="list-style-type: none"> • Identify claims that have errors which prevent them from getting into the processing system • Identify claims that were accepted by the processing system 	
Regence BlueShield	<ul style="list-style-type: none"> • Real-Time Confirmation Reports • Submitter Daily File Confirmation Report • Provider Daily Claim Confirmation Report • Sender and Payer Confirmation Report 	<ul style="list-style-type: none"> • Confirmations of claims sent that day as well as payer contractors that have responded on that day. • Gives submitters with a daily summary of claims activity at the file level. • Gives submitters a daily summary of claims activity-by provider number • Gives submitter with a daily summary of Sender /Payer responses by submitter and provider 	All of these reports are produced by THIN (Clearinghouse)

The following conditions may result in a claim not appearing on a 997, an 835 or one of the above reports.

- *Invalid Member ID*: When a claim is received for a patient with a member ID that is not valid, the claim cannot be processed.

- *Duplicate Claim:* Some health plans may not respond to a duplicate claim if that claim was received within 30 days of payment of the original claim.
- *System Problem:* There may be situations where claims are not being processed as expected. Health plans resolve these situations as soon as they become aware of them.

Institutional Provider Organizations can submit a Health Care Claim Status Request and Response 276 ANSI ASC X12N transaction (276) to request the status of a submitted claim.

4. Will Institutional Provider Organizations receive an unsolicited Claims Status Response (Unsolicited 277)?

No, unless otherwise indicated in the table associated with question #3 above. The Unsolicited 277 is not a HIPAA mandated transaction at this time.